After Five Decades, Can Health Care Costs Be Controlled Without Sacrificing Quality?

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As the war in Europe was winding down in the mid 1940s, while still in medical school, I remember being told by one of our professors, Dr J. Robert Willson, that we would be seeing national health insurance in America within "the lifetime of our practice of medicine." Was it prophesy based on *crystal-ball gazing*? Actually, he had just returned from a conference in Washington, DC where federal involvement in health care was discussed, and he was obviously impressed.

By that time, Great Britain was well on the way toward establishing National Health Service (NHS).[1-4] The initial NHS proposal was brief and very broad. It was referred to as *The White Paper* and was only 85 pages long. The White Paper was originally written to be "attractive, lucid...free from verbal ambiguity..." and, of course, free of controversy. This can be accomplished only by omitting details relating to such items as organization, health centers, hospital and special services, staffing, distribution of doctors, and home care, to name a few.

Briefly, the White Paper started with four major proposals,[3] which hardly sounded like socialized medicine.

1. Freedom to use or not use facilities; no compulsion into service either for patient or doctor.
2. Freedom for people to choose their own medical advisers.
3. Freedom for doctors to pursue their professional methods in their own individual way.
4. The personal doctor-patient relationship was to be preserved and the whole service founded on the concept of the *family doctor.*

In charge would be the Minister of Health, responsible directly to the Parliament. Available to him or her would be two statutory Central Health Service Councils (one for Scotland and one for Great Britain proper) made up of doctors, nurses, dentists, and pharmacists. The latter entity had no executive powers and its duty was to render advice on technical and professional aspects, reporting only to the Minister of Health.

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Very shortly and as expected, deviation from earlier stated principles occurred in all areas. The bureaucracy expanded relentlessly. The Central Medical Council, started as two, became six in a matter of weeks. At every level administrative bodies were established. The freely elected Central Medical Boards became more and more appointed. Proposals for hospitals expanded to 40 proposals. There was a plethora of confusing statements like "NHS is not a matter of poverty and wealth," that "it was not for charity." "Everyone would pay for a service for everyone by taxation" in part through Social Security Insurance contributions, but "there would be no charge for the services." One member of the House of Lords said the governmental intentions were honorable, but "good intentions were not good enough," and that the White Paper was written "without sufficient knowledge."[4] Another member of the House indicated that "the establishment of a medical inspectorate...[was]...not very dissimilar from a medical Gestapo."[4] Nevertheless, NHS came into being with federalization of hospitals, doctors, dentists, nurses, others, etc, in early summer of 1948. Thus, from the beginning, the primary decision for socialized medicine was made and any *salesmanship* was for the purpose of obtaining cooperation, primarily from physicians and the British Medical Association. Doctors, of course, had no choice as to their participation, although at one point a threat to boycott was made by doctors.[5]

In the United States, President Clinton is not the first president to propose a national health care plan. There were proposals in the early 1930s, followed periodically by proposals in the mid 40s, mid 60s, early 70s, late 80s[6] and now, recently, 1994. President Roosevelt in 1945, in his annual message on the State of the Union, declared, "adequate medical care" to be one of the "basic human rights." The battle cry of the extremists was that national health insurance is "socialism and communism worthy of inciting to revolution."[7] Ten months later, in a special message to Congress, President Truman recommended that this *right* be made effective through National Health Insurance and related measures.[7] It was the first time in American history that a full-length presidential message dealt solely with health care. The reactions of Americans were mixed. Some spoke of it as a "milestone in health care progress." Others were in disbelief that Truman would propose *socialized medicine*. Characteristic over the decades will be the pattern of what occurred thereafter. Congress followed up in 1947 with two proposals. One entitled National Health Insurance and Public Health Act of 1947 (Senate Bill 1320) introduced by Democrat Senators Wagner, Murray, Pepper, Chavez, Taylor and McGraff.[8] The other, at the same time, is the National Health Act of 1947 (Senate Bill 545)

introduced by the Republican Senators Taft, Ball, and Donald.[9-10] The primary difference regarding NHI is always whether the government does or does not have the right to exercise any supervision or control over the administration of health care, personnel, maintenance, or operation of the state plans developed. Neither measure passed (congressional *gridlock*?). However, a multitude of health care proposals continued to be introduced over the years contributing to changes in the practice of medicine. It is difficult to name all the proposals, much less in chronological order. Many fell by the wayside before or shortly after introduction; others took years to implement or were subsequently modified. However, the following is an attempt to demonstrate the influence of the federal government on the practice of medicine.

The need for more hospital beds throughout the country was recognized. In the 40s, indigent people were taken care of primarily by state and city hospitals. There were about a million government beds while the private or voluntary beds numbered close to 400,000. To deal with this situation, the Hill-Burton Bill was proposed and passed. For construction of hospitals, federal funding on a matching basis became available to states. The change in the need for private hospitals came about because Blue Cross, started in the mid 30s, became established a decade later.[7,9] This enabled many people, previously considered *indigents,* to go to private hospitals. The Philadelphia General Hospital, a 2,500-bed city hospital, experienced a drop in acute care patients noticeably by the late 40s. Within the next three decades the previously *unthinkable* happened, the famous hospital closed.

The motivation for governmental concern has been the unmitigated rising cost of medicine.[11-18,21-26] The medical literature is replete with this issue into the 70s and 80s with such adjectives as *spiraling, fantastic, soaring, astronomical, and uncontrolled.* The doctors, hospitals, labor, and pharmacists were blamed. In the 50s, health care workers were getting very low wages and began to demand higher wages. In Hawaii, the workers were seeking wage parity with California, which was 2 to 4 times higher. Nationwide, labor stated unequivocally that they would not relent on the issues of wages. Meanwhile, the physicians' fees were very low at that time, $5 to $10 a visit, and had to increase. The cost of drugs started to rise. There seemed to be an explosion of technology in various areas of medicine providing new services, many not inexpensive. Advances in instrumentation, equipment, and specialized technical services were expensive. In Hawaii, hospital-bed rates and associated service charges meanwhile had risen three times faster than wages.[17]

In 1966, Medicare and Medicaid were passed. For many of the hospitals, this was to be the beginning of about 15 years of financial difficulties with rising costs on one hand and increasing governmental restrictions on reimbursement on the other.[18-23,25,27-30,36-43] The government started with a proposal that hospital administrators make some effort to control costs internally. A range of measures were addressed such as waste management, energy management, preventive maintenance, food service, efficiencies in operation, and use of generic drugs rather than proprietary drugs, to name a few. Then came *cost containment.*[18-19] One of the early regulations was reimbursement based on "cost or charges, whichever was higher." A nursing home in Hawaii eliminated central air conditioning and substituted individual room air conditioners with increased cost. Needless to say, this particular regulation was not widely publicized and lasted a very short time. Other proposals continued and prospective reimbursement guidelines covered even wider areas such as physical therapy, rural hospitals, respiratory treatment, etc. As part of *All-inclusive rate* reimbursement (a precursor of DRG), diseases were separated into three general categories: medical, surgical, and obstetrics. Criteria were established for length of stay for different diseases. Utilization review became an important function in hospitals with attention to documentation in medical records by attending physicians. Notes in charts on treatment and patient progress were scrutinized by insurance clerks to justify every day of hospitalization. Based on this, at times, there was *retroactive denial* of payment for *excessive days* of hospitalization. To appeal for payments for those days, lengthy medical explanation needed to be submitted. This appears to fit in with the attitude, "If voluntary effort fails, cost controls will follow."[25] By the early 80s, a number of hospital closures had occurred.[30]

When disease-related group (DRG) reimbursement was proposed by Medicare in September of 1983 under the Reagan administration, there was to be fixed payment for each illness.[27-30] Since about 40% of the hospitals' total revenue was Medicare, the fear of bankruptcy was still foremost in the minds of the hospital administrators (facetiously, "Da Revenue's Gone").[30] Under considerable pressure, the hospitals undertook various measures to avoid bankruptcy.[30] They laid off workers and stopped hiring. Then some hospitals, with advice from consulting firms, *improved* the coding to maximize Medicare reimbursement. Patients recently discharged to decrease utilization were *readmitted with a different diagnosis.* When the government discovered these measures, the hospitals and doctors were accused of collusion. Sanctions were instituted if there were any evidence of a second DRG, eg, abnormal laboratory studies detected in the first admission, payments for the second admission were denied. There were instances where physicians were deemed to be responsible for the charges unless they had notified the patients properly, in writing, in advance. The hospital diversified into rehabilitation, long-term care, and home care for those patients who needed continued care beyond the allowable limits.[30] Home care went from 15% in 1983 to 35% in 1990. Some hospitals even went into unrelated areas including travel, health clubs, and collection agencies, to name a few. (They also got into tax problems.) The hospitals also attempted to set up more complex, higher-paying conditions as, for example, open heart surgery. These services increased from 10.5% in 1983 to 15.2% in 1991. The outpatient workload increased about 27% in 1991. The percentage of hospital revenue from outpatient department increased from 13.4% in 1983 to 25% in 1992. Thus, instead of falling, revenues and profits increased from 1985.

In 1956, the Relative Value System was being developed by various specialties in an effort to establish a logical, uniform method of determining fees. The Federal Trade Commission, in the mid 70s, had the antitrust section of the Justice Department look into RVS.[31-32] Needless to say, the physicians dropped RVS. From time to time, FTC continues to look into areas where fees are being established.

Meanwhile, what is the status of Resource-Based Relative Value Scale system passed by Congress in 1992?[33-35] RBRVS has a five-year phase-in period started in January of 1992. During this time, there are adjustments in fees with an increase of about 15% for those services that are underpriced, and during the same period, those fees that are higher will be reversed. RBRVS is complex with a number of factors brought into the establishment of fees, including volume, geographic variation,

specialty differentials, and peer review. Of course, self-referral will be disallowed.

In the mid 70s when managed care was first proposed, it looked like NHI was *just around the corner*.[6,44-45] Carter derailed efforts toward NHI because he did not believe continuing rising costs could be controlled through NHI. He was right. Costs still have not come down, even with all the regulatory measures that have been put in effect through the years. At that time, managed care was "on the fringe of health care system." Today, it is very much *the system*. It is estimated that "three-quarters of the private practice physicians participate in at least one HMO, PPO or IPA contract...derive an average of about one-third of their revenue from managed care..."[36] It consists primarily of two components: the purchasers and the providers.[36-41] The former includes businesses, insurances, government, and any entity seeking medical service. The latter are the providers, mainly the hospitals and doctors. The purpose is, "best care at the most reasonable or lowest cost." The providers are involved in "financial risk sharing" through capitation. There is implication of *rationing*. Is there going to be "deliberate withholding of potentially beneficial care?"[46] To say that some form of rationing does not occur in the United States now is naive. In a recent article, the distinction between the term *implicit* rather than *explicit* is made. "Implicit rationing can be carried out in a variety of ways: by budget, as when capitated health plans limit certain services; by price, when services such as cosmetic surgery are not covered by health insurance; by queue, when certain services are not immediately available; by hassle, when administrative barriers facing physicians and patients deter the delivery of services; by insurance coverage; and by subtle social factors."[46]

Ultimately, from the standpoint of patients, the change likely to occur is mainly the quality of service for two groups of patients:

- Individuals with common, ordinary *aches and pains*, especially the conditions considered to be non-life threatening, or *chronic*. In Great Britain, the waiting period for care of these diseases in the different districts ranged from 2 1/2 to 4 years depending on the district. The suffering is difficult to measure.
- Those (generally the elderly) afflicted with advanced disease, cancer, stroke, Alzheimer's disease, or chronic pulmonary disease to name a few, for which cure is extremely remote at best. Will the cost factor alter or even deny treatment of these patients?

From the standpoint of physicians, will it be necessary to have *gatekeepers* and *hatchet men*? Will insurance companies or hospitals remove medical staff who do not comply? Apparently, this has occurred recently in Hartford, Connecticut, where a lawsuit was filed by patients and doctors against an insurance company.[43] AMA has proposed the Patient Protection Act to assure fairness and accountability in the way insurance companies operate many of these plans.[36] Are the patients and doctors only *pawns* in this endeavor? Will the relationship between the patients and the doctors become one of estrangement? Who protects the doctors, controlled economically, without the freedom to practice medicine as they believe; yet, saddled with responsibility and accountability for *following orders*. Who protects him or her from *the attorneys in the alcove*?

At the moment, it appears that managed care will keep the federal government at bay, or limited to the uninsured segment of the population. If the private sector, businesses, insurance companies, and hospitals can take care of health care at a profit, why would the federal government want to be involved with the kinds of costs involved in national health insurance? The irony is that all through the years, we were worried about federalization of health care.

I have always considered the expression of medical philosophy to be caring and beautiful: Cure sometimes, help often, comfort always. Why does it now sound so discordant? Is it time for physicians to pause and reevaluate the situation?

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